**Patient Registration Form**

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address, city, state, zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor/responsible party/name of insured if different than above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Gender: Male Female

Marital status: Single Married Separated Divorced Widowed

Name of significant other if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Part time Full time Retired

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring physician name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ (initial here) By initialing this section and signing below, I acknowledge that I signed a copy of the IA notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full notice. I understand that a copy og the current notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available upon request.

\_\_\_\_\_\_\_\_(initial here) By initialing this section and signing below, I authorize IA to send me educational and/or marketing information on the products and services offered by IA. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

How did you hear about us? (Please select all that apply)

\_\_\_\_\_\_Friend/Family member \_\_\_\_\_\_Doctor \_\_\_\_\_\_Direct mail

\_\_\_\_\_\_Website \_\_\_\_\_\_Facebook \_\_\_\_\_\_Open House

\_\_\_\_\_\_Sign \_\_\_\_\_\_Internet \_\_\_\_\_\_Health Fair

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We will make a copy of the front and back of your insurance card and driver's license or identification card for our records.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_